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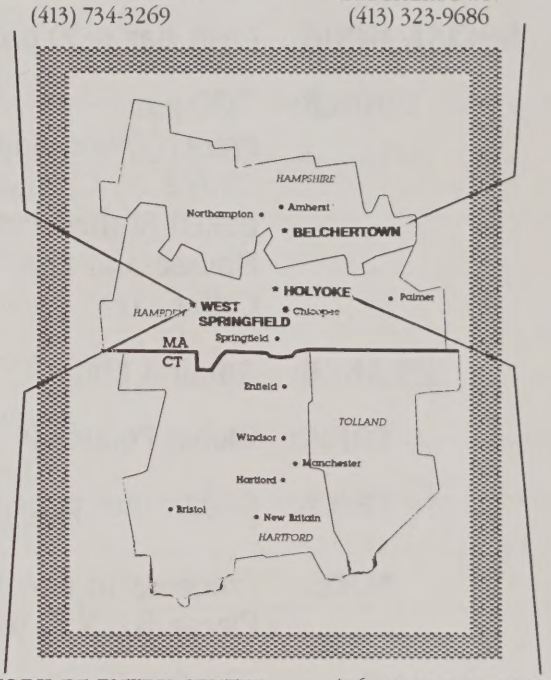

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THE HAMPDEN HIPPOCRAT

MAY-JUNE 1990
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On our cover is Ludlow Hospital in Ludlow, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HDMS President's Message

Nancy L. Weiss, M.D., President

As I am ending my tenure as Hampden District Medical Society President, I have reviewed my goals for these twelve months. If you recall, I wanted to improve our relationships among ourselves and towards various groups including our patients, the public at large, the legislature and organized medicine. Others I did not even tackle, knowing MMS is working on them, namely the Board of Registration in Medicine, the JUA, the insurance industry, etc. I think I have been reasonably successful in reaching these goals.

The most visible goal reached will be our move to a new office at 1111 Elm Street, West Springfield, some time this summer. This is in an attractive building with good parking that is easily accessible to the public and close to most of our hospitals. The tough negotiating done by Dr. Joseph Keenan, resulted in affordable rent. Our staff is very pleased with it, excited by this move, and feel they will now be working in a classy place.

Another goal visibly reached has been an improved relationship with the AMA and MMS. Dr. Tupper, President-Elect of the AMA, was very impressed with our turnout at the January meeting, our questions to him and that we could arrange 13 "media contacts" for him. MMS, at our urging, has instituted their only regional office, (in Northampton) and with them we are running two pilot programs. The first, to take place on April 27, 1990, will let 7 local legislators each spend an entire day with their own preceptor-physician learning about patient care and medical practice and learning their impact on it. The second is a "meet the candidates" series for us and our families. We will meet the gubernatorial candidates and ask them hard questions about their stands on health care and other issues. We, at HDMS initiated both of these programs, while MMS provided the know how to see them through, an encouraging example of cooperation.

Reaching other goals such as improving relations among ourselves often involved phone calls or corridor conversations that took more energy than I believed possible, but usually had positive outcomes.

There is a Chinese curse which says, "may you have an interesting life". Well, I have certainly had an interesting year. It has impressed upon me the need for us to be politically knowledgeable and active. I have learned how very lucky we are to have our devoted and hard working office staff, Carol Nystrom and Donna Zitka. And finally, I have enjoyed it. Thanks. ■

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From The Editors

March 12, 1990

Dr. Terry Ryan has edited the Hampden Hippocrat for many years. The quality of the journal has greatly improved in terms of both content and layout. Dr. Ryan has made arrangements for the journal to be self-supporting. Having invested a great deal of time and effort in these tasks, he has now stepped down as the editor and turned the task over to us.

The Hampden Hippocrat will continue to be "general purpose" journal devoted to the concerns of physicians in the region. As it is an official organ of the Hampden District Medical Society it will continue to serve as a source of information regarding the transactions of that organization. We will continue to offer a variety of articles and would request three things from our readers:

First, if you run across one of us and have any particular feelings about an article please let us know. Second, if you desire to write an article, review a book, be interviewed, or submit an article from another periodical that you would like to see reprinted in the Hippocrat, please let us know. Third, if you would like to help with the ongoing task of putting out this journal, please join us.

We look forward to hearing from you. ■

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IN MEMORIAM

DR. DOUGLAS G. SUITOR

Dr. Douglas G. Suitor, 77, of Fort Meyers Beach, Fla., a retired anesthesiologist at Baystate Medical Center, died March 23rd in Southwest Florida Regional Medical Center.

He interned at the Springfield and Wesson Maternity Hospitals, now Baystate Medical Center.

During his residency in anesthesiology at the Lehey Clinic, he trained directly with Dr. Frank Lehey.

A Navy veteran of World War II, he served in the Pacific Theater from 1942 to 1946.

After the war, he returned to the Baystate Medical Center as one of their first anesthesiologists. He helped to organize the anesthesiology department with Dr. Harry Strachan and Dr. Henry Memery in 1946. He practiced in Springfield, retiring in 1974.

Born in Deerfield, he attended the University of Vermont and Springfield College.

He was a 1940 graduate of Tufts Medical School in Boston.

He was a diplomat of the American Board of Anesthesiology.

He was a member of the New England Society of Anesthesiologists, the Massachusetts Medical Society, the American Society of Anesthesiology, and the International Society of Anesthesiologists.

He leaves his wife, the former Louise Lane, two sons, Douglas Jr., and Robert; a brother, John, and three grandchildren. ■

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Ludlow Hospital

This is the eighth in a continuing series of articles featuring Western Massachusetts Hospitals

A hospital rumored to be on the brink of closing its doors at the beginning of 1988, Ludlow Hospital has made an astonishing recovery and is moving into the 90's with renewed energy. Its vital signs are increased Medical Staff, new technology, innovative programs, and a balance sheet showing a profit for the past two years.

Its escape from the fate of many small community hospitals is the result of strong local support and a Board of Trustees, Medical Staff, Administration, and employees determined to meet the acute care needs of the Ludlow area.

Board Chairman, Joseph A. Gallo reported at the end of 1988, "The Board and Administration did what they had to do" to make sure that "the acute care facility would never leave Ludlow." One major task was to search for and establish a new service needed in the area and which would bring financial stability to the hospital.

Harvey M. Grant, M.D., Chief of The Ludlow Hospital Medical Staff

The answer to this challange is The Rehabilitation Hospital of New England, or Rehab West. Although separate and autonomous, Ludlow Hospital and Rehab West offer a continuum of care unique in western Massachusetts. In the spring of 1988, the state Department of Public Health gave its approval to a plan to convert 50 of Ludlow Hospital's 94 beds from acute care to inpatient physical rehabilitation. Rehab West will focus on care for young adults as well as an older population, according to Barbara Rohan, interim administrator of Ludlow Hospital from October 1987 to January 1990 and co-founder of Rehab West with Janet Hanna, Vice President of Re-Hab Associates, Inc., Rohan is President of Re-Hab Associates, one of the founding organizations of Rehab West, and CEO of Pioneer Valley Health Systems Inc., the parent corporation of Ludlow Hospital.

Marilyn M. Riddle, CEO for Rehab West, said the new center will offer comprehensive rehabilitation for head and spinal cord injury, stroke, amputation and orthopedic problems; management of chronic pain; treatment of Guillain—Barre; and cancer rehabilitation.

Ludlow Hospital will provide services such as Laboratory, Radiology, and Dietary, as well as acute care to Rehab West.

James Divver, CEO for Ludlow Hospital since January 1990, said the recovery of the hospital follows a 20 percent pay increase for nurses, operating a "lean, mean, low cost" facility, and identifying the community's health care needs. By November 1988 the census was up, there was higher revenues from several departments and services, and the Medical Staff expanded by 15 physicians.

The hospital is in the process of identifying and setting up ambulatory off-site clinics to serve its patients and physicians in Palmer, Wilbraham, and Monson.

Harvey M. Grant, M.D., is Chief of the Medical Staff. He sees Ludlow Hospital as a place where physicians and patients can have a closer relationship than is possible in larger hospitals. He said, "In a smaller hospital the patient isn't just a number." A special advantage to both patient and physician, he said, is the advanced technology available for diagnostic testing and fast results.

Ralph N. Otto, M.D., Chief Pathologist, commented on the state of the hospital: "Administration is the best we've had, Medical Staff quality is higher, professional services are top notch. Radiologists and Pathologists and other support people are experienced with the latest technology.

We have 90 to 95 percent capability in testing that larger hospitals have and are linked to other labs to get what we don't have." He feels Ludlow Hospital meets physicians' needs. "We get spoiled here," he said, largely because the hospital is small enough and flexible enough. "You don't lose anything by not being a megalopolis. The linkage is close. People know that how their department operates has something to do with the health of the hospital."

Laboratory services, including chemistry, special chemistry, hematology, microbiology, and surgical pathology, can in most cases give tests results the same day. The hospital runs a courier service for laboratory specimens to cities throughout the greater Springfield area.

Ludlow's new whole body CT scanner will be in place this spring. Among its features is the bone zoom function which can enlarge in the high resolution display delicate portions of the human body such as the inner ear. The CT will be available seven days a week, with Radiologists at the hospital five days a week and technicians and Radiologists on call.

In place of Ludlow's Radiology Department are Real Time Ultrasound and full array of Nuclear Medicine services. Gerald LaPierre, M.D. is Chief Radiologist.

The hospital has a year-old Mammography program serving women in Ludlow, Indian Orchard, Wilbraham, and Hampden. Patients can have a mammogram and see the Radiologist the same day.

At the heart of the hospital is patient care, and Ludlow is known for its T.L.C. and dedication to excellence. Margaret Bacon, R.N., Director of Nursing, said, "Because we're so small, we can give more personalized care and

attention. We have fine up to date equipment, and we can handle what we have to do.''

Emergency service is outstanding at Ludlow Hospital. Twenty-four Emergency Physicians give 24-hour coverage and are certified in Advanced Cardiac Life Support. Emergency Nurses have gone through a comprehensive emergency education program provided by the state and are certified variously in Emergency Medicine, Critical Care, and Pediatric Emergency Medicine.

The ER serves an average of 1,200 patients a month, or 14,700 in 1989. Waiting time is minimal.

Surgery services include the Same Day Care Unit which gives careful attention to patients undergoing minor surgery such as cataract, orthopedic, GYN, and hernia procedures. Among recent acquisitions in the OR are a phacoemulsifier for cataract surgery.

A Critical Care Unit is well staffed, with four Cardiologists and nurses trained in Advanced Cardiac Life Support and Critical Care Nursing.

An in-house Oncology Team meets weekly to review the status of each cancer patient. Through an organized assessment and plan of care, the team coordinates interdisciplinary communication in order to provide the best possible treatment. Sensitive to the needs of the community it serves, Ludlow Hospital has initiated some vital outreach programs: the Center for Eating Disorders, Medifast, the Pioneer Valley Counseling Center, and screening for hypertension, diabetes, cholesterol, and peripheral arterial disease.

The Center for Eating Disorders offers a medically directed multidisciplinary outpatient program. Each patient is evaluated by a clinical social worker, nutritionist, and mental health professional. A plan of treatment is tailored to each person's needs, and Lexie Elliott, Ph.D., of Boston Children's Hospital comes to Ludlow to assist with the program. Support groups meet regularly to help patients cope with anorexia and bulimia.

Medifast is a weight loss program developed by the National Institute of Maryland to treat obesity and related medical problems. Under the direction of Adnan Dahdul, M.D., Medifast helps patients learn skills and techniques to alter bad eating disorders and improve their chance for long-term health.

Pioneer Valley Counseling Center is a professional mental health service offering individual psychotherapy and family / couples, family, and group counseling. Additional services offered are: parent education, stress management (corporate and individual), psychiatric consultation referral as needed, group psychotherapy, psychological testing referral, and assessment and referral to appropriate resources when indicated.

It is clear that this hospital has gone beyond mere survival. Its patients will continue to have the option to receive acute care and rehabilitation care close to home. Staff at all levels is keeping its equilibrium during a phase of construction and renovation. Trustees, Medical Staff, and Administration are positioned for success.■

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The Good Old Days

During the olden days, there was an occassional clinical instructor who seemed to take pleasure in demonstrating the intellectual deficiencies of those he was expected to teach. This of course does not happen any more.

When I was rotating through Neurology as a first year resident (PGY-2) the chief of Neurology, Dr. H _____ was on service. He had just recently taken over a department which had been leaderless for about three years. He inherited a number of Neurology residents. All except one was a United States citizen and a graduate of an American medical school. The individual in question was a Parsi from India, whose English, although fluent, was marked by a striking accent. Since Dr. C _____ and I were both on the consult service, we got to know each other quite well and remain friends to this day.

The chief of Neurology was a brilliant teacher, and rounds were always stimulating. After Dr. C _____ and I had seen all the patients, we would meet in the clinic area and present one or two cases to our mentor. He would then digress at length on some aspect that interested him. Afterwards, we would leave the building and walk the block or so to the hospital where we would see the patients. During this walk, Dr. H. _____ would usually hold forth on some topic not related to medicine—sailing; an article on Noam Chomsky he had read in the *New Yorker;* some current event; but very often, he would comment at length on the lack of interest the new generation of physicians had in the world around them, or on their weak powers of observation.

He was particularly hard on Dr. C _____, even though he had me and several medical students to pick on—I suspected Dr. H _____ was miffed that he had a foreign medical graduate in his program. Dr. C _____ took the nearly daily humiliation cheerfully, but when we were alone he expressed increasing bitterness.

One day as we were walking from the clinic to the hospital, Dr. H _____ began his usual persecution. After again pointing out Dr. C _____'s shortcommings, he paused before the cornerstone of the hospital. "This is what I mean," he said, addressing all of us, including a young neurologist who was interviewing for a position on the faculty, and a colleague of Dr. H _____ who was going to give Neurology Grand Rounds later that week.

"We have been walking past this cornerstone every day, and I'll bet that none of you have the faintest idea of what this phrase means. In the days when this building was constructed, people would carve their most profound thoughts into stone for generations to read and reflect upon." Dr. H _____ continued to wax eloquent upon this theme, making side excursions into Gothic architecture and stained glass windows and recalling for us many of the inscriptions in English which graced our federal buildings in Washington.

Now I could read a little Latin and I was beginning to suspect that Dr. H _____ could not; his ethnic background was more consistent with a working knowledge of Hebrew. But I was deferential and certainly had no intention of any action which would lead to a confrontation.

Dr. H _____ paused and turned to Dr. C _____, "Dr. C _____," he said in a patronizing tone, "perhaps I am being too hard on you? Would you care to tell us what gem of wisdom is contained on that stone?"

Dr. C _____ looked at me, and with an expression that suggested he had finally reached his breaking point, he drew himself to full height and almost clicked his heels.

"Yes sir," he said. "The inscription reads 'This building was erected through the generosity of the D _____ family and the people of the diocese of S _____, and was dedicated by Bishop Anthony McNeil on July first, in the year of our Lord 1894.'"

Dr. H _____ turned a deep shade of red, and silently continued to the hospital where he was uncharacteristically quiet and uninvolved.

Dr. C _____ told me later that when he was growing up in India he had gone to a school run by a Catholic missionary order and had been instructed entirely in Latin for eight years. He also told me that he would soon be leaving, since on the morning of the event in question he had sent off a letter accepting an appointment in another fellowship position. ■

D. J. Higby, M.D.

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The Regional Office

As the Commonwealth of Massachusetts prepares for the 1990 elections, the Massachusetts Medical Society has embarked upon an extensive Political Education Program entitled, **PATIENT CARE '90.**

Never before has there been a better time, or more compelling reasons for physicians to become politically active. In November, the citizens of the Commonwealth will elect a Governor, Lieutenant Governor, Attorney General, and at least twenty-five new members to the House and Senate. Your vote is your power, and provides you an unprecedented opportunity to exercise your individual political influence, and help determine who will make the key health policy decisions for Massachusetts in the Nineties.

The **PATIENT CARE '90** Campaign is being coordinated by Alex Calcagno, Political Education Specialist at the Massachusetts Medical Society. The program will establish the Society and its membership as an important presence in the 1990 elections. Alex will facilitate the involvement of members, and position the MMS as a non-partisan resource for all of the candidates.

The first plank of the program is a statewide plan to increase the number of physicians who are registered to vote. Voter registration clerks will be available at district meetings and in area hospitals. Voter registration information will be coming to you through various Society communications. Your vote is your voice in the election. It is the first and most important step you can take to becoming politically active.

The second tier of the program is to broaden the theme, **PATIENT CARE '90**, to an agenda which includes the priority issues regarding Massachusetts health care. Such information will be shared with campaign staffs, to help shape the health care debate, as well as with members who may use it as a tool to evaluate a candidate's health care platform.

The Massachusetts Medical Society will position itself as a non-partisan resource for the candidates and Society members. A number of exciting programs are possible including a health-care debate between the candidates, forums with the candidates, as is currently being coordinated with the Hampden District Medical Society, and political education seminars. Programs will be tailored to meet individual district and regional needs.

The Massachusetts Medical Society is a non-partisan organization and cannot favor or endorse individual candidates. **PATIENT CARE '90** is an effort to encourage Society members to become politically active and help all the candidates better understand the dynamics of health care in the Commonwealth.

For more information, or if you are already involved in a campaign, please contact Alex at 1-800/322-2303. ■

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News From The JUA

We awoke Monday, April 2, to news that, for customers of the JUA, malpractice insurance rates for 1991 would be going down if the proposal filed by the JUA with the Division of Insurance is approved by the Commissioner. Richard Moore, President of the JUA, denied that the timing of the press release was related in any way to the proposal to institute "no-fault" insurance. That bill is currently before the Massachusetts legislature and is supported by the Massachusetts Medical Society.

The JUA proposal would reduce premiums for all rate groups across the board by 15.2% for holders of mature claims made policies and 18.1% for holders of occurence policies. Many are concerned that any rate decrease will be nullified by an increase in the DPL—the additional premium that all physicians who practiced in the state in the years 1983 to 1985 and are still in practice are paying. This surcharge represents an additional 15 to 60%, making effective total premiums much higher than those used by the JUA in their press release to suggest that Massachusetts rates are much lower than in "problem" states, such as New York and Florida.

Mr. Moore however denied that any large increase in the DPL is anticipated by the JUA. The size of the DPL for the rate year beginning July 1, 1991, will not be determined until approximately February, 1991. Mr. Moore attributed the sharp rise in the DPL between 1987 and 1988 to the fact that the DPL for physicians who retired by a certain date was "forgiven".

The JUA, according to Mr. Moore, is still expecting to be allowed by the Division of Insurance to collect a surcharge for losses sustained in the years 1975-1982 that were not covered by the premiums collected during those years. The JUA's proposal is to collect this surcharge from all physicians practicing in the state at the time it is imposed, including those who are no longer insured by the JUA. Since 1991-1992 is the last year of the DPL payments, it seems likely that such a surcharge might appear at the point that the DPL expires. Mr. Moore gave the HIPPOCRAT an extensive interview which will be published in our next issue.

Brigid Glackin, M.D.

Committee Reports

Dr. Walter Tauber, Chairman of the Tax Supported Medical Care Committee, wishes to remind all members that the Welfare Department pays $55.00 to $100.00 for a medical evaluation, rather than the previous $25.00

The Public Health Committee has been considering what sort of project to undertake this year. At the January 30th meeting, Commissioner Cipolla was a guest and suggested that the Medical Society support two case workers so that the program previously funded by the state to deal with the problem of infants born to addicted mothers could continue. These individuals bring together resources to educate the follow-up on the health and social needs of these mothers and their children.

The Committee will continue to look into this area.

The Medico-Religious Committee began planning for next year's Sixth Annual Medical Ethics Forum, which will be held on October 24, 1990, at Mercy Hospital, in the Deliso Center. The format will tentatively be to have a main speaker, with a panel of local experts to lead the discussion. Fr. John Tuohey was suggested as a possible speaker.

The Public Relations Committee continues to arrange meetings with candidates for political office. Work continues on a regular "spot" on Channel 40 to deal with medical issues of interest to the general public.

The Executive Committee continues its search for new office space. The legislative intern program is planned for April 27. The Committee decided to contine its non exclusive agreement with Monarch Life Insurance Company. ■

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Francis Riley? He's Back

Dr. Francis Riley, for 24 years a Springfield obstetrician, returned to Massachusetts in 1987 after a hiatus in Arizona. Doctor Riley had come to Springfield originally from the Harvard Medical School and the Barnes Hospital in St. Louis. He recently discussed his experiences in an interview with Dr. Glackin.

"I was in solo private practice in obstetrics and gynecology in Western Massachusetts from 1956 to 1980. I visited my MD daughter in Tucson, Arizona several times beginning in 1978, always in February when it was cold here and warm there. I bought a small winter town house in Green Valley, Arizona in 1979, in order to escape the cold weather here. I was offered a job with the Arizona Blue Cross and Blue Shield HMO in Tuscon in 1980 and I decided to try it. I moved in June, 1980, and bought a larger townhouse in the foothills of the Catalina mountains, north of Tuscon. I was intending to stay for the duration.

"I immediately did not like the job, even though I was doing the same work. The work was with patients whom I did not know and with M.D.'s in my section that I did not know and often did not like. I must say that I missed what I had taken for granted—the personal contact with patients who were my own. Nonetheless, I was determined to stay, if possible. I had two children at the University of Arizona who had moved out with me. I had sold my house in Longmeadow after one year.

"In the HMO practice, I did not encounter problems with the office billing or with multiple third party insurance plans. There was no medical malpractice insurance to pay and no difficulty with getting patients. However, I did encounter problems inserting myself into the medical community as an HMO M.D. (who was referred to as a communist) and as an older individual (I was 54). I liked Arizona because of the climate, which was warm or warmer for 8 months and hot for 4 months, and because of the scenery with the Grand Canyon in the North and the Sonorah Desert in the South. I also liked the proximity to California which was only 450 miles away. I did not like the fact that in Arizona the politics were mostly Republican and I did not like the two class society of the haves and have nots with few middle class people.

"I contracted Coccidiomycosis involving the lung and one knee joint in November 1985, which convinced me that I probably should leave the area. I got a job on old Cape Cod, which allowed me to leave. I worked there for just 6 months at the Cape Cod Hospital before I moved back to Western Massachusetts in May, 1986. I did not like Cape Cod because it was too wet and because the Cape Cod hospital is not the best."

Q: When you went into solo practice in Springfield in 1956, was that very unusual?

A: "Most of the obstetricians at that time were in solo practice. The only time I used to sign out was when I went out of town, which was probably once or sometimes twice a year. I had my office in my house, first in Springfield on Wilbraham Road, and later in Longmeadow on Williams Street."

Q: So when your daughter left to go out to Arizona you had been in practice for 20 years. Were you looking for a change in the style of your practice?

A: "I think the main reason why I went out there is because I always thought at a certain time in your life it might be stimulating to try something else. I always thought that the world was bigger than Massachusetts."

continued

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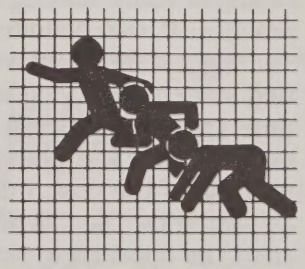

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Francis Riley? He's Back! continued

Q: Some physicians who have recently left Massachusetts have a lot of feelings about how the practice here has become particularly undesirable. Was there any of that feeling?

A: "I think that when I left here in 1980 I saw very little of what was to come very shortly. There was very, very little medical malpractice litigation at that time in this state and there wasn't the amount of third party interference that developed shortly afterwards. I was looking forward to going into a group where I could share responsibilities with other people. I found out that even in the larger group, I was still working more or less by myself."

Q: Wasn't it overwhelming to think about coming back?

A: " Well it was not just overwhelming for me. To be perfectly frank with you, it was embarrassing. I did not think it was my right to return here or to expect to be welcomed back here because I left in the first place. I had been very well treated before and I was actually perfectly happy here. I wasn't sure how I was going to be received back here when I decided to return. It was a very interesting position."

Q: In Arizona, you had surely heard about the changes in the private practice of medicine everywhere in the 1980s with Massachusetts identified as having had an overdose of regulation. Did that cause you any special concern?

A: "I heard from different individuals that things were supposedly worse here than in a lot of other places. It was my observation in Tucson that things for the medical profession were not easy there and I also heard that in other states such as California they weren't so easy either. So it was my opinion that things were probably not necessarily any better or worse in Massachusetts."

Q: What was the biggest surprise when you first came back?

A: "When I came back here I think that I had the distinct feeling of really starting all over again in private solo practice. It was definitely harder the second time. The biggest difficulty was the financial part of getting started and trying to earn my living at the same time. I found that almost impossible to do. I did finally decide that I was going to stop obstetrics, mostly because of the cost. I didn't think I could afford to do obstetrics. The difference in malpractice insurance costs, as opposed to doing gynecology alone is so drastic. That wasn't an issue in 1980."

Q: Do you particularly miss obstetrics?

A: "Not any more than you would expect to miss something that really is some kind of hard work. I don't actually miss obstetrics, it just happens to be a type of work I probably know best and do best."

Q: As you look back on your career, do you feel that the practice of medicine has evolved to the point that you are no longer practically happy with it?

A: "I don't really have any big regrets about having gone into medicine and especially after having done obstetrics and gynecology. I is a very, very difficult question to answer. As far as what I would personally recommend today, until the practice of medicine in the United States alters in some way, I am not sure I would really commend the practice of medicine to any person in whom I have a particular interest."

Q: Why is that?

A: "I think that the economic pressures on the practice of medicine by themselves are actually bad enough and then I think the actual dispensing of medical services in the United States probably could be better and more evenly done."

Q: So you think that as practitioners we have to wait for certain changes within the society before the practice of medicine will change?

A: "It is interesting that one of the biggest changes that took place in the field of OBGYN—the admission of abortions into the practice of OBGYN—came from outside of medicine. I think that in the final analysis, changes within medicine again probably will come from outside, not from within."

Q: Do you think that changes in the patient have changed medicine as much as anything else?

A: "As far as what American patients expect from American medicine, they probably expect more from American medicine then they have a right to, including in the field of OBS and GYN. The American people have lost sight of the fact that child bearing can be fraught with all kinds of dangers and risks in spite of the doctor."

Q: You have been active in public health issues and are currently Chairman of the Hampden District's Public Health Committee. What do you think are going to be the public health issues in the 90's? Can organized medicine have an impact?

A: " Well I think that medicine is probably the tail on a dog and not the dog itself, and the the dog wags the tail. I am not sure exactly what organized medicine can do for some of the problems that we have. I remember encountering a fellow who was in medical school at the time and he spent a brief period at Bellevue Hospital in New York. He was quickly disenchanted with the fact that he couldn't really do

much with these people medically who were already so deprived. They needed a lot more than just medical care. I really thoroughly disapproved of the reaction of that young medical student at that time. However, from a reality standpoint, while the doctor is aware of the existence for example of drug problems or problems of AIDS, he really doesn't necessarily have the power to do a great deal about many of these problems. Maybe the medical profession can come up with a vaccine for AIDS, but the whole community really has to be willing and able to respond to the matter of the treatment of people who have AIDS, and not necessarily try to exclude them from medical care or just generally from community life."

Q: You mentioned that the legalization of abortion changed obstetrical practice? What changes have you seen?

A: "When I was in residency training, if a patient had a pregnancy that was detrimental to her health, she was expected to continue with her pregnancy regardless of the cost to her, even if the patient would die."

Q: When you were first in practice, did you have patients approacing you for advice on illegal abortions?

A: "As far as I can recall, in absolute truth, I never had that put to me in private practice. What I did encounter is that people would have some unwanted pregnancy and would proceed to have the child and then at that time would be expected to be able to give up the child. It seemed to me that this requirement of the woman was much more harmful and hurtful to the woman then any abortion could possibly be. When the woman was asked or expected to give up some child she really didn' want, this really hurt the woman. And I saw a considerable amount of that and the damage that resulted from that."

Q: Any last word?

A: "It might seem appropriate for someone in my position to make a comment on the way things are today in medicine compared to what they used to be, but I really thoroughly disapprove of the notion that things were better in the old days than they are at the present time. I don't think anything is ever better in the old days than the present time." ■

Brigid Glackin, M.D.

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Sojourn In An Uneasy Land

EDITOR'S NOTE: *Cyril Shea recently retired from orthopedic practice in Holyoke and traveled to Haiti as a medical volunteer.*

On a cold winter's morning, last December, at about 6:30 a.m., I found myself on a jet airliner carrying me to the Caribbean via New York. I had a strange feeling that I might well be on the wrong plane. The assurances that I had received evaporated when I heard the pilot announce "snowy weather in Chicago." I shouted to the stewardess, "Are we stopping in New York first?" I demanded, with little hope of success, that I be let off the plane. Finally the plane stopped taxiing, returned to the gate and I was allowed to disembark. American Airlines, I must say, was in no way apologetic. Was this mix-up an omen of things to come, I wondered? Should I turn around and go home?

I persisted. Pan Am, though they had no obligation to me, got me to New York in time to make my Caribbean connection on American Airlines. We arrived in Port-au-Prince, the capital city of Haiti, late on a sunny afternoon with the air hot and heavy, to the sound of booming tom-toms. Hundreds lined the flat-top airport roof behind a heavy chain link barrier, shouting over the beat of the tom-toms to their arriving friends and relatives. An unfamiliar language, Creole, predominated though some spoke French. Soldiers patrolled carrying pistols or UZI machine guns. Going on into the customs area, I elbowed my way up to a young officious customs officer. Overbearing in manner, he demanded that I open my bag, but in fact he hardly looked at the contents. My surgical instruments escaped him entirely. The great mass of people moved like a turbulent current to the single exit. I hung onto my bags as I went. Once through the door I was uncertain as to what I would do next. Almost immediatly, however, I spotted a white face in the crowd and was relieved when I heard him speak English and identify himself as a Canadian religious Brother who was to be my host for the next twenty-four hours. At the same moment, I was hit by sudden panic. I appeared to have lost my instruments. I dashed into the surging crowd, fighting my way to the customs area. Halfway there, I realized that the instruments bag was hanging on a strap from my shoulder.

As we left the airport in Brother Luke's car, it was immediately obvious that I was in the midst of poverty of the most abject kind. Small jitney busses passed us. They were brightly painted in red with blue, green, yellow, orange and white markings. all had names. Some were place names or saints' names. They were designed to carry six or eight people, and were not much larger than military jeeps, but some were crowed with up to fifteen people, hanging from the sides and or the rear.

As we traveled the shabby streets, shopkeepers presented their wares on small stands in front of their houses. They sold items such as clothing, food, shoes, candies, toothbrushes, and sugar cane, Many buildings were either half built or half demolished. In Haiti it is common for a man to start the building of a house when he accumulated some money and to complete it only in stages depending upon, when and if, he is able to accumulate funds. In the meantime, he and his family live in the incomplete structure. The more substantial concrete buildings are protected by high walls and heavy gates. Lesser buildings have heavy wooden shutters and tall wooden doors, all of which are closed and locked tightly at night. In the gathering dusk, welding sparks flashed from the sidewalk. In another area a metalsmith sat by the road making pots and pans.

When we arrived at Brother's residence, I found a concrete and cinder-block building with high walls and a heavy iron gate. To my surprise, it was a leprosy clinic, I toured the clinic with Brother Luke. The clinic has state-of-the art medications, adequate clinical equipment and a computer. It is staffed by trained and dedicated Haitian physicians carrying on both clinical work and research. It is a well respected clinic and has international recognition.

The next day, on a clear Sunday afternoon, I took off in a small plane and flew over the vast mountain range which divides the plain of the south from the plain of the north. We went into a long slow climb to reach an altitude great enough to overfly these mountains which rise abruptly from the plains. We flew on in turbulent air. We bumped down safely at Cape Haitian International Airport. Despite its name it can handle only light planes.

At the airport I was met by a young Haitian cardiologist, who is also the medical director of the hospital in Milot in which I was to work. Haitians were forced to carry out a scorched earth campaign against the French during a slave revolt in the 1800s. My Haitian friends tell me that the country has never recovered. The land is in large measures deforested. The mahogany forests are gone. Rivers are drying up. Some of the fertile plains are turning into desert. Top soil has been washed into the sea. The fishing industry is almost non-existent. In December of 1989, almost two hundred years later, the country is still ruled by a General, and is politically unstable.

I worked in a small facility. It had about twenty beds in the main hospital and an annex with about fifteen more. Clinical buildings were built around a courtyard again with a high and heavy gate for security. In the countryside, homes were small and were built of some type of mud walls applied over a lattice work of sticks. I lived in the complex called Crudem which encompasses

several projects run by the Brothers. This includes a school, some farm projects, a brick factory, a hospital and administrative facilities. Our amenities were rather primitive. Blackouts were frequent. Telephone service was erratic. The water system frequently shut off. Many times showers were taken by pouring a bucket of water over one's head. The food was excellent. Haitian cooks are among the world's best. Haitian coffee is strong but good.

The clinical facts of life were difficult to deal with. I was quite isolated. The operating room was unsophisticated and cluttered. The equipment was generally old and in various stages of disrepair. Ampules of various medications stood in disarray on an anesthesia stand. There was a two inch hole in the screen door to the operating room where a doorknob and lock had once existed. Flying insects were overjoyed to find this entry way.

I had no effective way of communicating. My interpreter diligently accompanied me to the operating room but his fluency was poor. He had no medical knowledge. I had counted on Brother Yves, administrator of the entire project, to guide me in my endeavors but unfortunately upon my arrival at Milot, I found that he had to leave in twenty-four hours due to some unexpected emergency. I also learned that the hospital administrator was away. The hospital administrator is also a nurse-anesthetist and is in fact the only anesthetist for the hospital. I had specifically planned my trip to coincide with the presence of these key personnel.

In the operating room I limited myself to the simplest of procdures, doing them under local anesthesia. I had no assistant. I picked my own instruments. I scrubbed my hands over an open sink while a nurse poured water from a bucket, from time to time, on my hands. I brought a rubber tourniquet to the first operation and handed it to the nurse to be sterilized. It never appeared again until forty-eight hours later.

My clinic was perhaps my most successful venture. I saw some twenty or thirty patients per day with varying orthopedic complaints. Some had clear cut surgical problems with moderate severity that could have been treated in any average operating room at home but I dared not proceed under the circumstances. I saw many other patients with serious orthopedic abnormalities often as a result of old trauma. Some of these were totally beyond the limits of a facility of this type. I am hopeful that I will be able to make some arrangements for some of these cases on a teaching service here at home.

We were very limited in our drugs. Aspirin, Ibuprophen and Indomethacin were the staples in the orthopedic clinic. It is no exaggeration to state that Aspirin is as highly prized as virtually any drug imaginable. It is obtainable only on written prescription, and people are most grateful for it. One must constantly be aware of the supply of these drugs. Steroid injections were frequently indicated and were most helpful; however, the steroids quickly ran out. When an ampule is finished, the ampule washings using one or two CC's of Xylocaine were used. Often Xylocaine alone was used.

In spite of the many difficulties, I found the people most appreciative and thankful. My only regret is that I could not have done more. In spite of skies that are blue and sunny, the air seemed to hang heavy with shadowy portents. Incredibly, the kind and devoted Brother Luke had just one month prior to my arrival been shot through the forearm in a bizarre and confused encounter with uniformed police.

My good friends in Milot gave me a party the night before I left. They presented me with a Haitian painting. They asked me to return to continue helping them in the future. I was non-committal. I felt uncertain and inadequate. I think about them often.

I think about rivers running dry and fertile land turning to desert. I think of warm sunny days and tom-toms in the night. I think of high walls, locked gates and police check points. I think of an operating room with a broken door. I think of a clinic where Aspirin is King. I think of zombies toiling on farms in hinterlands, (a story unto itself.)

Will I return? Can I help? I don't know. I'm not sure. I've asked them to stay in touch.

Cyril Shea, M.D.

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Physician Self-Regulation: *The Board of Registration In Medicine*

This article was written by Anita F. Sarro, who is an attorney in the Springfield Law Office of Bulkley, Richardson and Gelinas.

The Massachusetts legislature has given the Board of Registration in Medicine significant powers. The power to determine who may be granted a license to practice medicine in this Commonwealth is the Board's most fundamental role. But the functions of the Board which have received the most attention in recent years are its powers to investigate complaints, initiate disciplinary proceedings and impose sanctions against licensed physicians.

These functions are not new. The Board for many years has had the power to initiate disciplinary actions and to impose appropriate sanctions where circumstances warrant. The Board did not exercise these powers vigorously in the past, however. Following the passage of the Medical Malpractice Reform Act of 1986, the Board was encouraged—more correctly stated, it was required—to reacquaint itself with these functions and to take a more active role in the regulation of its licensees. The activation of the Board's regulatory role was an important component of the legislative reform. Self-policing and self-regulation—of doctors and by doctors—was to provide the public with the assurance that professional incompetence would not be tolerated and to reduce the need for patients to seek redress in the courts.

The Board has the ability to "revoke, suspend or cancel the certificate of registration, or reprimand, censure, impose a fine not to exceed ten thousand dollars for each classification of violation, require the performance of up to one hundred hours of public service, require a course of education or training *or otherwise discipline* a physician"... (G.L. c. 112, sec. 5, emphasis supplied). Thus, the Board has a wide range of sanctions available to it to discipline licensees.

Before invoking this sanction power, however, a majority of the Board must conclude that there is satisfactory evidence that the physician has done one of the following:

(a) fraudulently procured a certificate of registration to practice medicine;
(b) is guilty of an offense against any provision of the laws of the Commonwealth relating to the practice of medicine, or any rule or regulation adopted thereunder;
(c) is guilty of conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct, gross incompetence, gross negligence on a particular occasion or negligence on repeated occasions;
(d) is guilty of practicing medicine while the ability to practice is impaired by alcohol, drugs, physical disability or mental instability;
(e) is guilty of being habitually drunk or being or having been addicted to, dependent on, or a habitual user of narcotics, babiturates, amphetamines, hallucinogens, or other drugs having similar effects;
(f) is guilty of knowingly permitting, aiding or abetting an unlicensed person to perform activities requiring a license for purposes of fraud, deception or personal gain;
(g) has been convicted of a criminal offense which reasonably calls into question his ability to practice medicine;
(h) is guilty of violating any rule or regulation of the Board governing the practice of medicine.

The Board examines evidence—documents and testimony—presented at a hearing conducted by the Board, at its Boston offices, and under its rules and regulations. These hearings are far from informal. A hearing officer presides over the proceedings, and the Board is represented by a Prosecuting Attorney. Both the Prosecuting Attorney and the physician's representative may call witnesses, cross-examine the opposing party's witnesses and submit written arguments for the Board to consider. These hearings, with all their formalities, are intended to afford the physician whose license is at risk the opportunity to hear the evidence being submitted to support the sanction and the opportunity to refute it and provide additional evidence for the Board to consider. These are the attributes of "due process", that is, the right to hear the accusations of wrong-doing and the right to speak in one's own defense. The hearing is a formal proceeding, with high stakes for the physician involved. It must be taken seriously, and it should be undertaken only with the assistance of a representative familiar with the process and its unique rules.

These hearings are expensive and protracted proceedings, and the Board enters into this process only after an investigation has been conducted and a determination made that there is sufficient concern and a reasonable factual basis for proceeding against a physician with the goal of imposing sanctions. This investigative function—the preliminary, information-gathering phase—is far less formal than the hearing. There are few rules to guide its participants. But its informality should not be confused with its importance. The outcome of an investigation will determine whether formal proceedings are instituted.

How does a physician know that an investigation has begun? An investigation could be triggered by one of the several reporting mechanisms created by the Medical

Malpractice Reform Act of 1986. For instance, a mandatory report submitted by a hospital at which a physician has clinical privileges could raise sufficient concerns about a practitioner that the Board may feel compelled to look further into the specific incident or pattern of incidents disclosed. But sometimes an investigation arises out of an unsolicited complaint.

The Board is required to investigate "all complaints relating to the proper practice of medicine." G.L. c. 112, sec. 5. The statute says *all* complaints, regardless of who the complainant may be. In fact, a complaint could be brought by anyone—a patient, a colleague, a neighbor. As long as the allegations relate to "the proper practice of medicine," the Board is mandated to investigate the complaint.

The first step in the Board's investigation usually is to notify the physician of the complaint and its substance. Often, if the complaint is submitted to the Board in writing, the physician will receive a copy of the complaint itself. The physician also will be invited to submit comments to the Board regarding the complaint within a stated period of time.

At times, a physician will be tempted to ignore a complaint, particularly where the practitioner firmly believes that the allegations are utterly baseless. Alternatively, receiving notice of a complaint may trigger such outrage that the impulse is to call the Board's investigator immediately and refute the allegations on the spot, in no uncertain terms, and at full volume. Neither approach is helpful. Instead, a simple, straightforward response to the allegations, carefully worded and timely submitted, could clarify the incident giving rise to a complaint sufficiently for the Board to conclude that further proceeding are unnecessary.

So what should be done if a notice is recieved from the Board that a complaint has been filed? Consider the following:

1. Do not ignore the complaint. It will not go away, no matter how false you know it to be.
2. Fight the impulse to respond immediately by telephone.
3. Respond in writing within the time limit set by the Board, and, in responding, confine your comments to the allegations of the complaint. Clarify and explain, but do *not* offer unnecessary information. At best, extraneous information will only cloud the issues and could delay speedy resolution.
4. Finally, take it *very* seriously. The effects of an adverse outcome could be profound and far-reaching. Sanctions imposed by the Massachusetts Board could affect much more than a physician's Massachusetts license. The Federal Health Care Quality Improvement Act of 1986 requires the creation of a National Practitioner Data Bank, a clearinghouse designed to share information about adverse actions taken against physicians and dentists on a nationwide basis. An unfavorable outcome in Massachusetts will be reported to this data bank and will be disclosed to another state's equivalent of the Board.

Indeed, the Board had undergone significant changes in recent years. Some would say for the better, and some would disagree. But it is unanimous that the Board's investigative activities have dramatically increased during the late 1980's, and there is every reason to believe that the Board will continue vigorously to fulfill its legislative mandate in this respect. But not all complaints to the Board have factual basis. And not all investigations could result in formal proceedings and sanctions. With some knowledge of the process and with competent advice and counsel, it is possible to cooperate in an investigative process and yet emerge unscathed.■

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World Affairs Council Announces Formation of International Community Council

Henry Ford was wrong. America is not a "melting pot." It is a potpourri of the ethnic and cultural heritage of all its citizens. Western Massachusetts is a multicultural community. To promote cross-cultural awareness and understanding, the World Affairs Council of Western Massachusetts has brought together representatives of various ethnic organizations to create an International Community Council. The Chairperson of the organization is Beverly A. Holmes.

Leaders and representatives of the various ethnic groups have begun meeting to plan and provide a forum for the advancement of cultural activities, services, and information. A major effort by the organization will be an ethnic festival scheduled for May 5, 1991. Other plans include the creation of a directory of all ethnic organizations and contact people in the area, which would be beneficial to people newly arrived in Western Massachusetts.

The World Affairs Council has provided the group with support and services. The Italian Cultural Center has provided meeting facilities. Representatives from the following groups attend the meetings: Puerto Rico, Sweden, Norway, India, the Carribean Islands, China, Portugal, Afro-American, Kenya, Italy, Ireland, and Japan. All ethnic groups are welcome and encouraged to participate.

In announcing this newly formed organization, World Affairs Council Executive Director Sue Root said, "In a world in which ethnic and cultural differences cause division, the World Affairs Council is delighted to have the International Community Council as a positive means to exhibit the wealth of ethnic diversity in Western Massachusetts." ■

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MEDICAL:	McMaster University 1973-1976
INTERNSHIP:	Toronto Western Hospital 1976-1977
RESIDENCY:	University of Toronto 1977-1980
FELLOWSHIP:	University of Toronto 1980-1981
SPECIALTY:	Ophthalmology

Kathleen E. Carlson, M.D.
701 Enfield Street
Enfield, CT 06082

BORN:	November 14, 1947
PREMED:	Smith College, Northampton, MA 1965-1969 Wellesley College, Wellesley, MA 1970-1971
MEDICAL:	UMass Medical School 1980-1984
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When we blow out its flame.

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Felt in the human chest,
It is a soothing time
Of life always the best.

False love burns like a straw;
Short is its glaring flame.
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It shines in any game.

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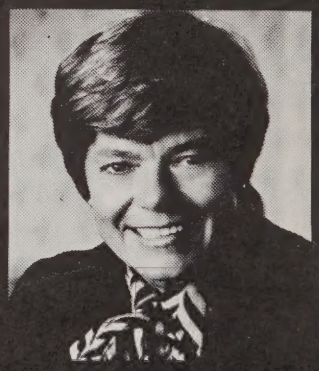

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